

Wisconsin Department of Regulation & Licensing

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BOARD OF NURSING

CERTIFICATION OF MASTER'S DEGREE

APPLICANT: Complete the top of this page and forward it to the college or university at which you received your master's degree. Request the college/university to return the completed form directly to the **Wisconsin Board of Nursing**.

Information requested is required for processing.

*SS# _____
(optional)

NAME: _____
(last) (first) (middle) (other/previous)

ADDRESS: _____
(street) (city) (state) (zip)

MASTER'S DEGREE PROGRAM COMPLETED AT: _____
(name of college/university)

LOCATION: _____ DATE OF COMPLETION: _____
(city) (state) month/year

I hereby authorize the _____ college/university to furnish the
WISCONSIN BOARD OF NURSING the information requested below.

DATE: _____ SIGNATURE: _____

DO NOT WRITE BELOW THIS LINE - FOR COLLEGE/UNIVERSITY

This is to certify that _____
(name)

successfully completed the master's program at _____
(name of college/university)

_____ and completed on _____
(city) (state) month/year

Was the master's degree in nursing? YES _____ NO _____

If no, please provide the title of the degree granted: _____

Was this college/university regionally accredited at the time of graduation? YES _____ NO _____

SCHOOL SEAL/STAMP

Signed: _____

*Voluntary, for use in school locating your records.

Title: _____

Date: _____